

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008441

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2480

FILED MAR 15 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN

ST. LOUIS, MO.

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Inside Limits

Yes ☐ No ☐c. CITY
OR
TOWN

St. Louis

d. STREET
ADDRESS

(If outside, give location)

5337 N. Union ave

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

HENRIETTE (HATTIE)

MASON

4. DATE
OF
DEATH

Month

Day

Year

MARCH

3

1962

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

OCT 17/84

9. AGE (last birthday)

77

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Ill's

12. CITIZEN OF WHAT COUNTRY

Yes

13a. FATHER'S NAME

ALEXANDER LAUVIER

13b. MOTHER'S MAIDEN NAME

MARY CHARLEVILLE

14. NAME OF HUSBAND OR WIFE

ARLEY DECEASED

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs Viola Ashner 5249 Thrush ave

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary embolism

(b)

Acute cholecystitis

DUE TO (c)

Ventricular aneurysm

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

585x

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☒ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20c. TIME OF INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 2-14-62

to 3-3-62

and last saw her alive on 3-3-62

Death occurred at 5:25

a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Robert L. M. M.D.

22b. ADDRESS

1515 LAFAYETTE AVE.

22c. DATE SIGNED

3/3/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

3/5/62

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St Louis Mo

24. FUNERAL DIRECTOR

ADDRESS

JOHN STYGAR & SON 5541 RIVERVIEW BLVD

25. DATE RECD. BY LOCAL REG.

MAR 4 1962

26. REGISTRAR'S SIGNATURE

Carl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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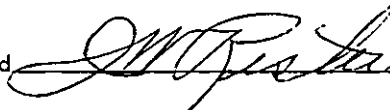
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No.

3980

P. O. Address



Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.